SECTION 13—BENEFITS AND LIMITATIONS

The Department of Mental Health, Division of Mental Retardation and Developmental Disabilities, operates three Medicaid Home and Community-Based Waivers for individuals who have mental retardation and/or a developmental disability (MRDD Waiver). No individual may participate in more than one waiver at a time. Many features of all three waivers are identical, but there are differences, as noted in this section.

Services under these waivers are provided as an alternative to an ICF/MR level of care or to allow a person to be discharged from an ICF/MR to the community. The provision of services through the waivers must be determined necessary to avoid institutionalization and the cost of services under the waiver must not exceed the cost that would otherwise be spent for services in the institution. Also, when a person is eligible for a State plan service and that service can meet the person's need, the person must access that service first.

The following Medicaid Home and Community-Based Waivers are administered by the Division of Mental Retardation and Developmental Disabilities:

COMPREHENSIVE WAIVER

Participants in this program must be eligible for Medicaid, be determined to have mental retardation and/or a developmental disability, and require ICF/MR level of care. Persons may require residential services or may be living in the community with family members. Refer to Section 13.7 for specific eligibility requirements.

MISSOURI CHILDREN WITH DEVELOPMENTAL DISABILITIES WAIVER (REFERRED TO IN THIS DOCUMENT AS THE SARAH JIAN LOPEZ WAIVER)

Participants in this program are not eligible for Medicaid under any State programs due to income and resources of parents being "deemed" to the child. Individuals must be less than 18 years of age, have a permanent and total disability, and live at home with their parent(s)/family. The individual must be determined eligible for ICF/MR level of care, be determined at risk of needing ICF/MR institutional care without access to waiver services, and must need waiver services. Refer to Section 13.7 for specific eligibility requirements.

COMMUNITY SUPPORT WAIVER

Participants in this program must be eligible for Medicaid, be determined to have mental retardation and/or a developmental disability, and require ICF/MR level of care. Persons do not require residential services and typically are living in the community with family members. The individual is at risk of needing ICF/MR institutional services if unable to access waiver services to subsidize care and support provided by the community and family. The estimated cost of

waiver services and supports necessary to support the person must not exceed $22,000 annually. Refer to Section 13.7 for specific eligibility requirements.

13.1 DMRDD ADMINISTRATION

Day to day administration of the three MRDD Waiver Programs is provided by the Division of Mental Retardation and Developmental Disabilities (DMRDD) within the Missouri Department of Mental Health (DMH). The DMRDD is authorized by statute to serve Missourians with mental retardation and developmental disabilities as defined in Section 630.005 RSMo (1994). Persons are served through the Division's 11 Regional Centers throughout the State. The Regional Centers are the point of entry for services. Not all persons eligible for services from the DMRDD are eligible for a MRDD Waiver Program. See Section 13.6 for information on eligibility for the waiver.

13.2 PROVIDER PARTICIPATION

To become a Missouri Medicaid Provider of MRDD Waiver services, potential providers must contact the DMRDD Regional Center serving the area where the provider anticipates delivering services. Applying providers must satisfy both DMRDD and Medicaid Agency requirements. When a waiver service is available in more than one MRDD Waiver program, once the provider is enrolled to provide a specific MRDD waiver service, the provider is an eligible provider in each of the waiver programs that includes the specific service(s).

13.2.A DMRDD PROVIDER REQUIREMENTS

The DMRDD requires all potential providers to meet the following requirements prior to becoming enrolled as an MRDD Waiver provider:

- Have a current and appropriate license, accreditation or certification for each specific waiver service that is provided;
- Have a current DMH, DMRDD Waiver Purchase of Service (POS) contract for the specific waiver service(s) that is provided; and
- If the waiver service "residential habilitation" is provided, have a current DMH, DMRDD Community Placement contract.

13.2.A(1) Obtaining a Provisional Certification Certificate.

Agencies planning to provide residential habilitation, individualized supported living, day habilitation (facility and non-facility based) and/or supported employment services which are not accredited by CARF or the Council on Quality & Leadership for Persons with Developmental Disabilities (the Council, formerly the Commission on Accreditation of Rehabilitation Services for people with Disabilities (ACD)) must obtain a Provisional Certificate of Certification from the DMRDD Regional Center for each specific waiver service they want to provide, prior to becoming eligible for enrollment as a DMRDD Waiver provider. To qualify for a Provisional Certificate of Certification requires the following action as stated in 9 CSR 45-5.060:

- A Certification Safety Review Form must be completed by regional center staff.
- A Self-Survey for Medicaid Certification Form must be completed by the agency with assistance from the regional center.

- A Medicaid Waiver Enhancement Plan must be completed by the agency with assistance from the regional center.

When all three documents are satisfactorily completed, the DMRDD Regional Center forwards the documentation to DMRDD Central Office and a recommendation is sent to the DMRDD Director recommending a Provisional Certificate of Certification be issued. The Provisional Certificate of Certification is issued for a one year period. The provider will subsequently be surveyed by Office of Quality Management Licensing and Certification within six months. A provider must obtain a provisional certificate for each waiver service they intend to provide.

13.2.B MEDICAID AGENCY PROVIDER REQUIREMENTS

At the same time the DMRDD Regional Center is assisting the provider in meeting DMH enrollment requirements, the regional center also gives the provider a Missouri Medicaid Provider Enrollment Application packet. All of the forms in the packet must be properly completed and signed according to the instructions provided. The following Missouri Medicaid requirements must be satisfied:

- Apply for and obtain a National Provider Identifier (NPI) at https://nppes.cms.hhs.gov/NPPES/Welcome.do prior to submitting the Missouri Medicaid Provider Enrollment Application.
- Complete the Missouri Medicaid Provider Enrollment Application packet, which must have an original signature.
- Complete a Missouri Division of Medical Services Remittance Advice on Tape Agreement, which must have an original signature.
- Agree to maintain for six years or longer, if specified by a contract with DMH, auditable program records reflecting services provided, recipient progress, number and kinds of recipients served and other relevant program records;
- Allow the Centers for Medicare and Medicaid (CMS), the Department of Social Services (DSS) or its authorized representative, DMH, to inspect and examine its premises and records that relate to the provision of services under this program.

13.2.C ASSIGNMENT OF MEDICAID PROVIDER NUMBER

DMRDD verifies that all DMRDD and Missouri Medicaid requirements have been met and forwards required forms, copies of DMRDD contracts and proof of appropriate license, accreditation or certification to the Medicaid Agency. Both DMRDD and the provider receive an approval letter from the Division of Medical Services (DMS) when the process is completed that includes the provider's NPI number and the effective date of Medicaid participation.

13.2.D REPORTING PROVIDER CHANGES

MRDD Waiver providers must notify the DMRDD Regional Center of any changes in status in writing. Notification must include the Medicaid provider number and description of the change to be made. Examples are changes in address or telephone number, changing from a Social

Security number to a Tax Payer I.D. number, changes in certification status, etc. The DMRDD forwards all changes to DMS and makes necessary modifications in its own records.

Specific information about Medicaid participation requirements for MRDD can be obtained from the DMRDD regional center serving the area where the provider intends to conduct business. Reference the map of the Regional Centers.

13.3 RETENTION OF RECORDS

Medicaid providers must retain for six years, from the date of service, fiscal and medical records that coincide with and fully document services billed to the Medicaid Agency. These records must be furnished or made available for inspection or audit by the Department of Social Services or its representative upon request. Failure to furnish, reveal and retain adequate documentation for services billed to the Medicaid Program may result in recovery of the payments for those services not adequately documented and may result in sanctions to the provider's participation in the Medicaid Program. This policy continues to apply in the event of the provider's discontinuance as an actively participating Medicaid provider through change of ownership or any other circumstance.

13.4 WAIVER PARTICIPANT SAFEGUARDS

The State must address participant safeguards for assuring the health and welfare of waiver participants. The three basic safeguards that must be addressed are:

I. **Response to Critical Events or Incidents** (e.g., abuse, neglect, and exploitation) that bring harm, or create potential harm, to a waiver participant.
II. **Safeguards concerning Restraints and Restrictive Interventions**. Restraints include personal restraints (e.g., holds), drugs used as restraints, and mechanical restraints. Seclusion means involuntarily isolating an individual as a means of controlling the person. Restrictive interventions restrict an individual's movement: a person's access to other individuals, locations or activities, or restrict participant rights. Restrictive interventions also include the use of other aversive techniques (not including restraint or seclusion) that are designed to modify a person's behavior.
III. **Medication Management and Administration**. This addresses medication management, which is the review of waiver participant medication regimens (e.g., the appropriateness of the medications that a person may be receiving) and medication administration (the administration of medications to participants who are unable to administer their own medications by waiver providers).

I. Response to Critical Events or Incidents

A. **Reporting Critical Events or Incidents**
The state in accordance with Department Operating Regulation 4.270 and Code of State Regulation 9 CSR 10-5.200 and 10-5.206 requires that the state report and investigate major and serious incidents by all employees of state facilities and community contracted providers.

1. It is the responsibility of contracted providers to notify the Department of Mental Health with a written or verbal report of all required incidents immediately unless otherwise specified on form DMH 9719 B. If a verbal report either by phone or in person is given the contracted provider must send a completed report on the DMH 9719 B to the Department the next working day.
2. The Code of State Regulations (9 CSR 10-5.206) requires that any director, supervisor, or employee of any residential facility, day program or specialized service, that is licensed, certified or funded by the Department of Mental Health immediately file a written complaint if that person believes a consumer has experienced an incident affecting the health, safety or welfare of a consumer; or has been subjected to abuse or neglect while under the care of a residential facility, day program or specialized service.
3. For DMH employees, complaints of abuse, neglect, or misuse funds/property shall be reported and investigated as set forth in Department Operating Regulation 2.205 and 2.210.

B. Participant Training and Education

1. Service Coordinators annually provide training and education by reviewing a Client Rights brochure with consumers and guardians.
2. The Missouri Department of Mental Health has a web site www.dmh.missouri.gov which provides consumers and families a link to view Client Rights, Abuse & Neglect Definitions, and the Reporting and Investigation process which includes contact information. The DMH Client Rights Brochure, the brochure on Individual Rights of Persons Receiving Services from MRDD, and DMRDD's process for informing staff, providers and consumers on reported alleged abuse or neglect is also available on the web site.

C. Responsibility for Review of and Response to Critical Events or Incidents

Each Regional Center receives all written incident reports from contracted providers. Reports are individually evaluated against set criteria for referral to the appropriate entity.

1. All suspicions of abuse and neglect and misuse of funds are referred to the Department of Mental Health Centralized Investigations Unit.
    a. If a provider reports a critical event and is responsible for oversight/safety of the consumer then action must be taken to assure the welfare of the consumer. The Regional Center may intervene by placing monitoring processes and staff at the program site or moving consumers from a home and/or terminating the contract when appropriate.
    b. If there is an allegation of abuse or neglect and the victim is a resident or client of a facility licensed by the Department of Health and Senior Services (DHSS) or receives services from an entity under contract with DHSS then a phone referral is made to DHSS regarding the allegation.
    c. If there is an allegation of abuse or neglect and the victim is less than 18 years of age a phone referral is made to Missouri Children's Division.

d. If there is alleged or suspected sexual abuse; or abuse and neglect that results in physical injury, or abuse/neglect or misuse of funds/property which could result in criminal charge then this is reported to local law enforcement.

2. Missouri Protection and Advocacy is notified by e-mail of all consumer deaths that involve death from a consumer being restrained and/or secluded, death from suicide, death deemed suspicious for abuse or neglect, unexpected death, or death with unusual circumstance.

D. Responsibility for Oversight of Critical Incidents and Events

The Missouri Department of Mental Health, Division of MRDD is responsible for the oversight of the state's incident management system which is currently housed in the Event Management Tracking (EMT) database.:

II. Safeguards concerning Restraints and Restrictive Interventions

A. Restraints

1. Department Operating Regulation (DOR 4.145) requires that each Department of Mental Retardation facility and Regional Center shall have written policies for the use of restraints and time out procedures. Facility policies are subject to review by central office.
2. State Regulation (9 CSR 45-3.030) requires that each provider shall have policies and procedures for the behavioral management of individuals served.
3. Seclusion is expressly prohibited. Lesser restrictive alternatives must be utilized first and restriction of movement may not occur without due process. Refer to (Revised Statutes of Missouri (RSMo) 630.110; Code of State Regulations 9 CSR 45-5.010 (3) (A) 5. A-N and the Medicaid Waiver Certification Guidelines, sections 3.2.05, 4.1.13, 4.1.14). Some rights may not be limited as outlined in state statute (RSMo 630.115).
4. All contracted providers are required to report the use of restraints on the Community Event Form 9719 B. The Service Coordinator will review the Community Event Form to determine if alternative methods were first used, if the restraint was warranted, if the restraint was implemented and outlined and approved in the personal plan and if the restraint was implemented by certified staff. If the service coordinator suspects abuse or neglect the documentation is entered into the EMT.
5. Use of any restraint technique must be approved by the human rights committee (includes parents of consumers and local advocates) and the behavior management committee (includes individuals with expertise in behavior intervention strategies) as outlined in DOR 4.145. The DMRDD consolidated contract requires that all residential providers with 10 or more consumers must have a human rights committee.
6. Clients may only be mechanically restrained after a written order has been made by a qualified mental retardation professional. Written orders for any restraints

shall be time limited and for no longer than 12 hours. Written orders must be placed in the client's record and it must contain the behavior that required the restraint, the type of restraint used, the time when the order was written, the time when the restraint was first used, and the criteria for discontinuing the restraint, and the time the restraint was discontinued.

7. In an emergency in which an on-site physician is unavailable, only a registered nurse or a qualified licensed practical nurse may administer chemical restraints to a client and only after receiving an oral order from an authorized physician. The documentation of such an order must include the name of the physician who gave the order, the name of the nurse who received the order, and the name of the nurse that actually carried out the order.
8. In an emergency, qualified personnel may initiate mechanical restraint procedures provided a qualified mental retardation professional is immediately notified. The qualified mental retardation professional shall observe the client and evaluate the situation within thirty (30) minutes from the time restraints were initiated.
9. Qualified personnel who may initiate mechanical restraints are :
    1. A psychologist with at least a master's degree from an accredited program and with specialized training or one (1) year of experience in treating the mentally retarded;
    2. A physician licensed under state law to practice medicine or osteopathy and with specialized training or one (1) year of experience in working with the mentally retarded;
    3. An educator with a degree in education from an accredited program and with specialized training or one (1) year of experience in working with the mentally retarded;
    4. A social worker with a bachelor's degree in social work from an accredited program, or a bachelor's degree in a field other than social work and at least three years social work experience under the supervision of a qualified social worker, and with specialized training or one (1) year of experience in working with the mentally retarded;
    5. An occupational therapist capable of securing a state license, or certificate, and who has specialized training or one (1) year experience in treating the mentally retarded;
    6. A physical therapist capable of securing a state license, or certificate, and who has specialized training or one (1) year of experience in treating the mentally retarded;
    7. A speech pathologist or audiologist capable of securing a state license or certificate and who has specialized training or one (1) year of experience in treating the mentally retarded;
    8. A registered nurse who has specialized training or one (1) year of experience in treating the mentally retarded;
    9. A therapeutic recreation specialist who is a graduate of an accredited program and who has specialized training or one (1) year of experience in working with the mentally retarded and ,
    10. Licensed professional counselors.

10. All contracted providers are responsible for ensuring that staff who administer any authorized restraints are adequately trained.

B. Restrictive Interventions

1. The Missouri Division of MRDD Consolidated contract states the rights identified in RsMO 630.115 may be limited if inconsistent with a person's care/habilitation. The person would have to be a danger to themselves or others.
2. Any restriction of rights must be documented in the individual habilitation plan. Consumer's must be notified of what rights will be restricted prior to implementation. The plan must lead to a less restrictive way of managing and ultimately eliminating the behavior necessitating the rights restriction.
3. The facility or center behavioral support committee, client rights review committee and the client's parent or guardian as appropriate review and approve the plan before implementation.
4. The Division of MRDD consolidated contract requires all contractors having a licensed, certified, or accredited residential capacity of ten (10) or more consumers appoint a consumer rights committee. The function of the committee is to review existing and planned programs, ensuring that legal rights of consumers are upheld as specified in RSMo.630.110. The committee consists of no fewer than five (5) adult individuals.
5. All contracted providers are required (CSR 10-5.206) to report to the Regional Centers any violation of consumer's rights.
6. All staff supporting individuals with behavioral needs must be trained in behavioral support strategies. All contracted providers are responsible for ensuring staff that restricts any consumer rights are adequately trained on rights restrictions.
7. All assigned service coordinators must be trained on Consumer Rights.

C. Responsibility for Oversight of Restraints and Restrictive Interventions

1. The Department of Mental Health, Division of MRDD, is responsible for overseeing the use of restraints and ensuring that the states safeguards are followed.
2. Regional Center Quality Management Staff analyze aggregate reports of incidents from the EMT database at least quarterly to identify trends and patterns. These trends are incorporated in provider Quality Management Plans, plans of correction and/or consumer's plan of care.
3. At least annually the MRDD State Quality Assurance Team prepares a statewide report which includes quality assurance and improvement recommendations to address patterns, trends and systemic issues. These findings and recommendations are submitted to the MRDD Division Director.

III. Medication Management and Administration

1. All HCBW Providers employ an RN for review and monitoring of participant medications regimen on a monthly basis. This is a monthly on-site review of medical records and a face to face evaluation of the participant performed by the RN with the responsibility to oversee and review medication usage patterns including routine and PRN medication, medication effectiveness, participant response and side effects. The RN is required to review all event reports for medication errors as well as hospitalization, significant change in behaviors and PRN psychotropic drug use and take necessary action as part of their oversight function. The findings are recorded in the RN's monthly summary which is shared with the provider management for planning and intervention as needed and integrated into the monthly review and personal plan as appropriate for the participant.
2. All state MRDD Regional Centers have Quality Management RNs who are responsible for monitoring participants medication regimens as part of their nursing review that is completed at least annually and anytime there is significant health changes for waiver placement participants who meet a score threshold on the health inventory tool and for all participants who are entering community placement for the first time.
3. The Health Inventory Tool is used to track the use of behavior modifying drugs as well as poly-pharmacy. A statewide database is currently being designed to automate the tracking of multiple psychotropic drug use for waiver participants which will allow further evaluation.
4. All persons utilizing behavior modifying drugs must have their plan reviewed and approved by a client rights review committee.
5. In accordance with 9 CSR 45-3.070, individuals who administer medication or supervise self-administration of medication to participants must be either a licensed physician, licensed nurse, or must be delegated the task of medication administration and supervised by a licensed medical professional after the individual obtains certification as a MRDD or DHSS Level I Medication Aide or Medication Technician as required prerequisite.
6. All non-medical personnel must successfully complete a DMH approved course in medication administration. The minimum classroom instruction/curriculum is 16 hours for initial certification and at least 4 hours of update every 2 years by an approved nurse instructor. In addition to course instruction and practice, the individual must pass a written test with at least 80% accuracy and must pass a practicum for passing medications with 100% accuracy.
7. Administration of medication through a gastrostomy or jejunostomy and Insulin administration requires additional training, delegation, and supervision by a medical professional.
8. Participants who self-administer medication must have a physician's order, must have demonstrated competency for all aspects of self-administering and this must be reflected in their plan of care.

9. Providers are responsible to document and report medication errors and their response to it, to their designated state MRDD Regional Center in accordance with Event Reporting regulation 9 CSR 10-5.206.

Responsibility for Oversight of Medication Management and Administration

1. The Department of Mental Health, Division of MRDD, is responsible for overseeing the use of medications and ensuring that the state's safeguards are followed. In accordance with 9 CSR 10-5.206 providers report the Regional Center all medication errors using the standardized community event form.
2. Findings discovered in the state and provider level of monitoring medication management are entered into a statewide database. At least quarterly the Regional Center Quality Assurance analyzes regional data from the statewide event database for trends and patterns and shares analysis with provider agencies resulting in Provider Quality Management Plans.

13.5 QUALITY ASSURANCE

13.5.A MO DMRDD QUALITY MANAGEMENT

Quality management is an ongoing process States must implement to ensure a waiver program operates as designed, meets statutory and regulatory assurances and requirements, meets intended outcomes, and identifies enhancement opportunities. The six areas of waiver assurance are:

I. Level of Care Determination;
II. Plan of Care;
III. Qualified Providers;
IV. Health and Welfare;
V. Administrative Authority; and
VI. Financial Oversight.

For each of the six areas, the State was required to describe in its quality management strategy, activities or processes related to discovery (monitoring and recording the findings); the entities or individuals responsible for conducting the discovery/monitoring processes; the types of information used to measure performance; and the frequency with which performance is measured. Additional detailed descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery were described through the approved waiver application although they may not be specifically identified in this summary. The following sections include CMS required assurances (bold/italics) and an abbreviated statement of processes the DMRDD has identified to address each component of the six waiver quality management assurances.

I. LEVEL OF CARE DETERMINATION

a. ***Waiver applicants for whom there is reasonable indication that services may be needed in the future are provided an individual level of care evaluation.*** QMRP-qualified

service coordinators employed by the state and local County (Senate Bill 40) Boards complete LOC evaluations for individuals requesting participation into the waiver.

b. ***Enrolled participants are reevaluated at least annually or as specified in the approved waiver***. At least annually, state and SB-40 service coordinators conduct LOC reassessments for all participants to determine continued eligibility for the waiver. The number of new and reassessments resulting in eligibility or ineligibility are tracked and reported on annually.

c. ***The process and instruments described in the approved waiver are applied to level of care determinations***. DMRDD Directive 4.060 outlines the process to review plans of waiver participants which includes requirements for reviewing LOC.

d. ***The state monitors level of care decisions and takes action to address inappropriate level of care determinations***. Regional Center QMRP supervisory staff reviews LOC determinations and DMS and DMRDD Federal Program Unit conduct a review twice a year that includes evaluation of LOC, annual re-determination, and assessments used to determine LOC for the sample participants.

II. SERVICE PLANS

a. ***Plans of care address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means***. DMRDD Person Centered Guidelines prescribe criteria for developing plans that will address necessary supports for health and safety of the participant.

- The Division's Policy, Training and Quality Assurance Unit evaluate a sample of plans from each region of the state to insure mandatory person center plan guidelines are implemented.
- DMS, in conjunction with MRDD Federal Program Unit, review a random sample of plans twice a year to assure participants' assessed needs are addressed, including health and safety risk factors, how supports will be provided, and personal goals.
- Regional Center Utilization Review (UR) Teams review plans for new participants and participants requesting additional services.

b. ***The State monitors plans of care development in accordance with its policies and procedures and teaks appropriate action when it identifies inadequacies in the development of plans of care***. DMRDD Directive 4.050 establishes the requirement for the person centered planning process and the content of individual service plans. DMRDD Directive 4.060 describes the process to ensure compliance with Medicaid waiver and DMRDD Directive 4.050.

- Using the Mandatory Components Personal Plan Review Tool, quality management staff monitors one (1) person centered plan (including amendments and documentation of progress) each month from each service coordination/SB40 team.
- Waiver audits through DMS, in conjunction with MRDD Federal Program Unit, assure plans meet Missouri person-centered planning guidelines.

c. ***Plans are updated/revised when warranted by changes in waiver participant needs***.

- Service coordinators assure each waiver participant has a plan meeting and a new plan completed each year. Records are reviewed for compliance that all services received are identified in the plan of care and that plans of care are current.
- DMS and DMRDD Federal Program Unit Waiver audit reviews monitor records for compliance that plans are current and all services are identified in the plan of care.

d. ***Services are specified by type, amount, duration, scope and frequency and are delivered in accordance with the plan of care.***

- DMS and DMRDD Federal Program Unit waiver audits review how services are specified and delivered as per the plan of care.
- DMRDD-approved volunteer advocates and/or family members complete the Missouri Quality Outcomes Measure Survey with randomly selected participants receiving a DMRDD and/or waiver funded residential and/or day habilitation service.
- DMRDD state QA staff complete annual on-site reviews with a minimum of five participants receiving residential and/or day habilitation services from each Regional Center.
- Service coordinators meet with participants to monitor services at prescribed times, or as needed by the participant.
- Annual provider monitoring by regional centers including evidence that paid services were provided and services authorized were the services provided.

e. ***Participants are afforded choice between waiver services and institutional care. Participants are afforded choice between/among waiver services and provider***.

- Service coordinators explain and offer choice of waiver services and providers for each participant.
- The DMS and DMRDD Federal Programs Unit waiver audit determines if individuals served are provided choice between waiver services and institutional care and choice of provider.
- Participants are free to express satisfaction or dissatisfaction with services through MO Quality Outcomes Measure Survey (See II.d).
- Service coordinator service monitoring.

III. QUALIFIED PROVIDERS

The State verifies on a periodic basis that providers meet required licensing and/or certification standards and adhere to other state standards. DMRDD Directive 5.060 outlines the process potential new residential and day habilitation providers must complete to become an enrolled waiver provider.

- Providers that are certified by the DMH Office of Licensure and Certification are recertified every two years.
- Providers that are accredited provide proof of continued accreditation.
- DMRDD conducts annual provider monitoring to determine if staff meet qualifications.

a. ***The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements***. DMRDD monitors providers annually to assure they meet qualifications.

b. ***The State identifies and rectifies situations where providers do not meet requirements***. Annually, DMRDD verifies that the provider has met all requirements and has proof of appropriate certification, accreditation, State licensing, or other requirements in order to continue as a qualified waiver provider.

c. ***The State implements its policies and procedures for verifying that training is provided in accordance with state requirements and the approved waiver***. DMRDD monitors providers annually to assure they meet qualifications.

IV. HEALTH AND WELFARE ASSURANCE

a. ***There is continuous monitoring of health and welfare of waiver participants and remediation actions are initiated when appropriate***.

- DMRDD Directive 3.020 prescribes the frequency of monitoring based on all service(s) that the waiver participant receives.
- Regional Center Quality Management staff review information twice annually for patterns or trends of consumers and/or providers. Meetings are held with providers to share information, discuss possible causes and solutions for all issues identified, and to develop strategies for systemic improvements.
- The Health Identification Planning System (Residential only) is a medical audit designed to safeguard participants who need significant supports for optimal health; and assure that those supports are in place through a professional nursing review.
- Residential contract providers contract and/or hire Registered Nurses (RN) to provide appropriate delegation and supervision of unlicensed staff who perform such duties as medication administration and other nursing tasks when applicable.

b. ***On an ongoing basis the State identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.***

- All community providers are required to report any instances of abuse, neglect and exploitation.
- Anytime there is suspected abuse, neglect or exploitation, the local Regional Center submits a request to the department's investigation unit for investigation. Information from the investigation is collected in the CIMOR EMT system.
- On a monthly basis QA staff collect statistics from investigations across the state and reports this to the DMH Quality Improvement Division's Score Card. This information is used to develop system improvement in prevention of abuse and neglect for the DMRDD.

V. ADMINISTRATIVE AUTHORITY

The Medicaid agency or operating agency conducts routine, ongoing oversight of the waiver program.

- DMS retains final approval authority for all decisions made by the operating agency including determinations, policies and procedures. DMRDD as the operating agency implements day to day oversight of operation of the waiver.

- DMS/DMRDD audits records of sample participants twice annually. This includes a comprehensive compliance review of assurances the state has made. In addition, the DMS SUR Unit conducts a financial review of payments made to waiver providers.
- The DMRDD Federal Programs Unit works with the State QA staff and Regional Centers to address issues identified, including training targeted to address trends locally or statewide as appropriate.
- DMRDD monitors County Boards that provide TCM that supports waiver participants for compliance with State and Federal laws and regulations, conditions of participation, and assurances. Direct services provided by County Boards are subject to the same standards and provisions as other providers.

VI. FINANCIAL ACCOUNTABILITY ASSURANCE

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

- At least annually a review is conducted by Central Office DMRDD Administrative Services and/or a Regional Center of one month of records (representing selected services for 5% of consumers or five (5) consumers, whichever is more) of each contract provider.
- DMS SURS Unit reviews documentation of waiver services paid by Medicaid for participants selected for review during the DMS/MRDD audit. The SURS Unit contacts providers that billed services for the participants and requests that documentation of delivered services be provided for review.
- UR Teams review all initial plans and budgets (and those with increased funding requests) to ensure person's needs are being addressed and that levels of funding for individuals with similar needs are similar statewide.

PROCESSES TO ESTABLISH PRIORITIES & DEVELOP STRATEGIES FOR REMEDIATION AND IMPROVEMENT

At least quarterly, Regional Center QA staff meets with each community provider's staff to review the provider specific performance data from all of the above waiver assurance activities, as synthesized through the CIMOR EMT and APTS data tracking systems, to identify any significant trends or sentinel events. Strategies and timelines for remediation and improvement activities is documented in the provider's QA Plan. Progress is assessed at the latest as part of the following quarterly review.

At least semi-annually, Regional Center QA staff conducts a similar review to identify region-wide trends and priorities for remediation and improvement. Strategies and timelines for remediation and improvement activities will be documented in the Regional Center's QA Plan. Progress is assessed at the latest as part of the following semi-annual review.

No less than annually, the State QA Team conducts a comprehensive review of the CIMOR EMT and APTS databases, the regional QA Plans for the past year and other Division performance measures to identify statewide patterns and trends. This will result in recommendations to the Division Director for approval of the MRDD QA Plan, which may include revisions to the QMS itself.

COMPILATION AND COMMUNICATION OF QUALITY MANAGEMENT INFORMATION

Information from all of the waiver assurance processes is input to CIMOR EMT and APTS data systems. Reports from these systems are reviewed as input to the QA Planning processes at each level. Additionally, DMRDD compares and analyzes statewide and region specific performance levels on a designated set of performance measures. The resulting report is available to all Regional Center staff and community providers but is not yet available to the public.

PERIODIC EVALUATION AND REVISION OF THE QMS

The annual review by the State QA Team leading to the MRDD QA Plan (above) is also a formal review of the effectiveness of the QMS and may recommend revisions to the QMS.

The DMRDD quality management system design has multiple functions. Each function has its own process for discovery of needs/issues/concerns, and action planning for remediation of problems. Systems improvement efforts are based upon the consolidation and analysis of data from all functions, as well as other information.

The strategy for quality management includes multiple "real-time" methods of feedback and information gather in addition to periodic inspection processes. Consumers (program participants) and community members are in active roles. The system utilizes quality improvement processes such as data analysis, tracking, and trending. Data bases in place for gathering information and subsequent analysis and trending include the Customer Information Management, Outcomes and Reporting (CIMOR) Event Management and Tracking (EMT) system, and the Action Plan Tracking System (APTS).

The recently-developed CIMOR EMT system contains events that previously were data based in the Incident and Investigation Tracking System (iiTS), a DMH data base for abuse and neglect investigations as well as for serious community events, and the Community Event Form Data Base (CEF), used by Regional Centers to track all incidents. The Action Plan Tracking System (APTS) is designed to track issues identified through the various quality management functions. Information from the various data bases results in the development and implementation of action plans, quality management plans, and/or quality improvement plans for individuals, contracted providers, and state staff both regionally and statewide.

13.5.B SERVICE COORDINATION MONITORING

Service coordination for DMRDD Waiver participants is provided by service coordinators employed by DMRDD Regional Centers or County SB-40 Boards that are approved by DMRDD to provide service coordination.

The service coordinator maintains at least quarterly contact with each participant or the participant's family or guardian. Face to face contact is required at least monthly for those

persons in placement and quarterly, but no less than annually, for persons who live with their family. During monitoring visits, the service coordinator monitors the individual's health and welfare. Progress notes document the contact and whether the outcomes stated in the participant's person centered plan are occurring and whether the outcomes set forth by Missouri Quality Frameworks, which is a revision of the Certification Principles, are a reality for the person.

It is also the service coordinator's responsibility to review the provider's progress notes at least quarterly and note any problems, discrepancies, dramatic changes or other occurrences which indicate a need for renewed assessment. The service coordinator's review of the provider notes includes making further inquiries and taking appropriate action if there is reason to believe the person's health or welfare is potentially at risk.

13.5.C REGIONAL CENTER QUALITY IMPROVEMENT TEAMS

Each DMRDD regional center has a Quality Improvement (QI) team that visits providers. Generally this is done together with certification for those agencies which are to be certified. These teams look for outcomes in accordance with Missouri Quality Outcomes, a revision of the Certification Enhancement Principles, and work with providers to develop action plans and periodically review progress with the provider. If a provider refuses to cooperate in taking corrective action by working on an action plan, regional centers can initiate intermediate sanctions such as discouraging new admissions or encouraging the development of new providers in the area. Also, regional centers can formally request the DMH certification team or the accrediting agency (CARF or The Council) to review an agency, can institute audit procedures concerning fiscal and contract compliance and can remove individuals from services and terminate a provider's DMH contract, if necessary.

13.5.D SAFE PROGRAM

Self Advocates and Families for Excellence (SAFE) is a statewide volunteer organization consisting of people with developmental disabilities / self advocates and family members of people with developmental disabilities.

Trained SAFE volunteers work in conjunction with the MO Department of Mental Health – Division of Mental Retardation and Developmental Disabilities (MR-DD) to help gather information directly from individuals with developmental disabilities about the services and supports they receive; how individuals with developmental disabilities feel about their lives; and to help determine the presence of the Missouri Quality Outcomes in their lives.

13.6 NONDISCRIMINATION

Providers must comply with the 1964 Civil Rights Act, as amended; Section 504 of the Rehabilitation Act of 1973; the Age Discrimination Act of 1975; the Omnibus Reconciliation Act of 1981 and the Americans with Disabilities Act of 1990 and all other applicable Federal and

State Laws that prohibit discrimination in the delivery of services on the basis of race, color, national origin, age, sex, handicap/disability or religious beliefs.

Further, all parties agree to comply with Title VII of the Civil Rights Act of 1964 which prohibits discrimination in employment on the basis of race, color, national origin, age, sex, handicap/disability, and religious beliefs.

13.7 ELIGIBILITY

The number of individuals who may be served in each year of a MRDD Waiver is prior approved by the Centers for Medicare and Medicaid Services (CMS). No additional individuals may be served. Eligibility for a MRDD waiver is determined by the Division's 11 Regional Centers.

The individual must be eligible for Medicaid coverage for each date of service for reimbursement to be made to a provider. If an individual is determined to no longer be eligible for Medicaid services past a specified date, the individual is also no longer eligible for waivered services after that date. Prior to admission to any waiver, the plan of care must go through the Utilization Review (UR) Process, whereby individual's needs are prioritized in order to identify and serve individuals with the greatest needs first. It is applied to all new plans of care and new/increased budgets developed by planning teams. The UR process is standardized for use at all regional centers, and it also applies to plans of care and budgets developed by SB-40 Boards. The process rates priority of need and assigns points with scores of 12 representing individuals who have the greatest need in the State. These persons are served first, followed by individuals with lesser scores.

13.7.A MRDD COMPREHENSIVE WAIVER ELIGIBILITY

In order to be considered for participation in the MRDD Comprehensive Waiver, an individual must: be eligible for Medicaid as determined by Division of Family Supports under an eligibility category that provides for Federal Financial Participation (FFP) (refer to Section 13.6.E for a list of excluded eligibility categories);

- be determined by the DMRDD regional center to have a developmental disability as defined by Section 630.00 5 (9) of RSMo, (1994); and
- be determined by the DMRDD regional center initially and annually thereafter to require an ICF/MR level of care if not provided services under the waiver.

The ICF/MR level of care requires the presence of mental retardation or a related condition as defined in federal rule (42 CFR 435.1010), plus a need for the level of care provided in an ICF/MR (42 CFR 440.150). In addition, it requires a determination that, but for the waiver, the applicant would actually be institutionalized in such an institution (42 CFR 441.302).

To access waiver services, Medicaid eligible applicants must first be determined eligible for DMRDD Regional Center services through an assessment process. The assessment includes the Missouri Critical Adaptive Behaviors Inventory (MOCABI) or for children, the Vineland or other age appropriate instrument(s). Observation, interviews and collateral information are also used. Once eligibility for regional center services is determined, a service coordinator uses the

gathered information and any other information needed to evaluate the applicant's eligibility for the MRDD Waiver Program. The service coordinator also develops an initial draft service plan containing the waiver services needed as an alternative to institutional care.

The regional center reviews the evaluation of level of care and draft service plan and, subject to the availability of waiver "slots" and funding, determines eligibility for the waiver.

42 CFR 435.1010 defines "Persons with related conditions" as follows:

Persons with related conditions means individuals who have a severe, chronic disability that meets all of the following conditions:
(a) It is attributable to—
(1) Cerebral palsy or epilepsy; or
(2) Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.
(b) It is manifested before the person reaches age 22.
(c) It is likely to continue indefinitely.
(d) It results in substantial functional limitations in three or more of the following areas of major life activity:
(1) Self-care
(2) Understanding and use of language
(3) Learning
(4) Mobility
(5) Self-direction
(6) Capacity for independent living

Service coordinators with the regional centers or with certain SB 40 Boards (County Boards) approved by the DMRDD may perform evaluations of level of care. The regional center administration reviews the evaluations and makes the determination of eligibility for the waiver.

13.7.B MRDD COMMUNITY SUPPORT WAIVER ELIGIBILITY

In order to be considered for participation in the MRDD Community Support Waiver, an individual must meet all of the eligibility criteria in the MRDD Comprehensive Waiver as listed above (13.6.A.1) plus the following criteria:

- The person has a place to live in the community, typically with family, and does not require residential services;
- The person has care and support needs that can be both safely and economically met in the home (cost less than the average cost of care in an ICF/MR).
- The initial plan of care estimates the total cost of waiver services necessary to meet the person's needs will not exceed $22,000 per year.

13.7.C MRDD MISSOURI CHILDREN WITH DEVELOPMENTAL DISABILITIES (SARAH JIAN LOPEZ) WAIVER ELIGIBILITY

In order for a person to be considered for participation in the Lopez Waiver, the individual must meet all of the following eligibility criteria. The individual must:

- Be under the age of 18 and must not be eligible for any regular Medicaid programs, including MC+ for Kids, also known as the SCHIP Waiver or the 1115 Waiver.
- Be living at home and cannot be in placement.
- Have a need for developmental habilitation (waiver) services. While s(he) may have extensive medical needs that could be met with State Plan Medicaid services, the individual must also require behavioral/habilitative services and/or family supports available as waiver services. The waiver services the individual is assessed to need must be ongoing services that the individual will need monthly or at least quarterly.
- Have care and support needs that can be both safely and economically met in the home (cost less than an equivalent level of care in an ICF/MR).
- The individual must have a permanent and total disability (PTD). Sufficient medical records must be provided so that the DFS Medical Review Unit can make the determination that the individual has a PTD condition. (The records will be requested for DFS review if a slot is approved.)
- Be determined by the DMRDD regional center to have a developmental disability as defined by Section 630.00 5 (9) of RSMo, (1994).
- Be determined by the DMRDD regional center initially and annually thereafter to require an ICF/MR level of care if not provided services under the waiver.

The ICF/MR level of care requires the presence of mental retardation or a related condition as defined in federal rule (42 CFR 435.1010), plus a need for the level of care provided in an ICF/MR (42 CFR 440.150). In addition, it requires a determination that, but for the waiver, the applicant would actually be institutionalized in such an institution (42 CFR 441.302).

In order for an individual to be determined to need a waiver service, this person must require at least one waiver service, as per his or her service plan. If the individual's needs are such that waiver service(s) are provided on less than a monthly basis, the waiver participant will require regular monthly monitoring – to be documented in the service plan.

13.7.D APPEAL RIGHTS

Anytime an adverse action is taken or a decision is made related to Medicaid eligibility, MRDD Waiver Program participation or access to specific waiver services, the individual has the right to request an appeal. Examples of adverse actions include:

(1) An individual is determined ineligible for Medicaid;

(2) An individual requests services through the waiver but is denied participation in the program;

(3) An individual participating in the waiver is denied a waiver service; or
(4) The level of services a participant has received in the past is reduced without the consumer's (or his/her guardian's) consent.

Appeals related to Medicaid eligibility decisions are the responsibility of the Department of Social Services, Division of Family Supports (see 13.6.D(1)). When the appeal concerns MRDD Waiver Program participation or access to waiver services, an individual has appeal rights with both the Departments of Mental Health and Social Services, Division of Medical Services. While not required to do so, MRDD Waiver participants are encouraged to begin with the Department of Mental Health's appeal process. The individual may, however, appeal to the Division of Medical Services, before, during or after exhausting the Department of Mental Health process.

Once an individual begins the appeal process through the Department of Social Services, an appeal process through Department of Mental Health shall not begin, or if in process will terminate, since the Department of Social Service is the single State Medicaid Agency and any decision through that agency would supersede a decision made by Department of Mental Health. The individual's service coordinator will assist the individual with either of these appeal processes (see Section 14.8 for more details).

13.7.D(1) Department of Social Services, Division of Family Supports Appeal Process

If an individual is denied eligibility for Medicaid or the individual's Medicaid eligibility is terminated, the individual has the right to appeal the decision to the local Division of Family Supports County Office. An individual may call, write or come to the office to request a hearing. A hearing is scheduled within 90 days after the date of the adverse action date.

13.7.D(2) Department of Mental Health Appeal Process

The Department of Mental Health's appeal process is summarized as follows:

- Within 30 days of the denial, the individual must notify the regional center that the individual wants to appeal.
- Within ten days the regional center director notifies the individual of the appeal decision.
- Within 30 days, the individual may notify the regional center that the individual wants an appeals referee to hear the case.
- Within 60 days of requesting a hearing with an appeals referee, a hearing before an appeals referee is held.
- At least 30 days prior to the hearing, the individual is notified of the date of the hearing.
- Within 30 days after the hearing, the individual is notified of the referee's decision.
- Within 30 days, the individual may notify the Department of Mental Health director that the individual wants to appeal further.
- Within ten days, the individual must submit evidence to the Department director.

- Within 20 days, the individual is notified of the director's decision on the appeal.
- Should the individual disagree with the Department director's decision, the individual may appeal to the Circuit Court, according to Chapter 536 of the Revised Statutes of Missouri (RSMo).

13.7.D(3) Department of Social Services, Division of Medical Services Appeal Process

An individual may contact the Division of Medical Services to request an appeal of DMRDD Regional Center decisions related to MRDD Waiver Program participation and access to waiver services. The request for an appeal must be initiated within 90 days of the date of action. To request an appeal through the Medicaid agency, an individual may write to the Division of Medical Services, Recipient Services Unit, P.O. Box 6500, Jefferson City, Missouri 65102-6500 or call the Recipient Services Unit at (800) 392-2161.

13.7.E MEDICAID ELIGIBILITY CATEGORIES EXCLUDED FROM MRDD WAIVER PARTICIPATION

Some individuals, who are eligible for services through the Missouri Medicaid Program, are not eligible to participate in the MRDD waivers. Since MRDD Waivers offer services as an alternative to institutional care, persons who are residents in Medicaid funded institutions such as ICFs/MR, and nursing facilities are not eligible.

Additionally, persons who are eligible for Medicaid under certain categories of assistance are not eligible for participation in the waiver. Following are some common eligibility categories that prohibit individuals from participating in a MRDD Waiver.

13.7.E(1) Blind Pension (ME Code "02")

Individuals who receive Medicaid services through the Blind Pension Program are not eligible for participation in the Home and Community Based Waiver Program. Services provided by Medicaid to individuals with this eligibility status are paid with state funds only. Federal matching funds are not available for services that these individuals receive through Medicaid.

NOTE: Individuals eligible for Supplemental Aid to the Blind (ME code "03") are not excluded from MRDD Waiver participation.

13.7.E(2) Limited Benefit Packages (ME Codes 55, 58, 59, 80, 87)

Individuals whose eligibility is restricted to "QMB-only" (ME code 55), "Presumptive Eligibility, non-subsidized" (ME code 58), "Presumptive Eligibility-subsidized" (ME code 59), "Women's Health Services" (ME code 80) and "Presumptive Eligibility Child" (ME code 87) are not eligible for participation in the MRDD Waiver Program.

- Uninsured women who do not qualify for other benefits and will lose their Medicaid eligibility 60 days after the birth of their child may continue to be eligible for family planning and limited testing and treatment of sexually transmitted diseases, regardless of income, for two years after the pregnancy ends (ME code 80/Level of Care code O).

13.7.E(3) General Relief (ME Code "09")

MRDD Waiver services are not covered for individuals who are eligible for General Relief. See Section 1 for further information about Medicaid eligibility requirements.

13.7.E(4) DFS Children's Services (Adoption Subsidy) (ME Code "08")

Children served through the DFS Children's Services program who have a type of assistance (TOA) code of "Z" may not participate in the MRDD Waiver since federal matching funds are not available for services these children receive through Medicaid.

13.7.E(5) 1115 Waiver (ME Codes 71, 72, 73, 74, 75, 76)

Persons who become eligible for Medicaid through an eligibility expansion category under Missouri's 1115 Waiver are not eligible to participate in the DMRDD waiver. These individuals have gross income that exceeds guidelines for regular Medicaid eligibility. This program is also referred to as MC+ for Children (Kids) and MC+ for Adults. See Section 1 for further information.

Following are the expanded eligibility categories under the 1115 Waiver:

Children without private insurance in homes with gross income that exceeds regular Medicaid eligibility guidelines but is less than 186% of FPL (ME code 71, 72 & 73/Level of Care code 1).
Children without private insurance in homes with gross income between 186% and 225% of FPL (ME code 74/Level of Care code 2).

- Children without private insurance in homes with gross income between 226% and 300% of FFP (ME code 75/Level of Care code 3).
- Adults losing Transitional Medical Assistance who are not otherwise insured or Medicaid eligible, with gross family income up to 300% of the federal poverty level (ME code 76/Level of Care code E).
- 13.6.E(6) MO Children with Developmental Disabilities (ME Codes 33, 34)
- Individuals who receive Medicaid services through the MO Children with Developmental Disabilities are only eligible for participation in the Sarah Jian Lopez Waiver Program.
- Persons eligible for Medicaid in the above categories are eligible for varying packages of covered Medicaid services. For questions regarding specific covered services for individuals in these categories, contact the local Division of Family Supports Office. To determine if a recipient is in one of the above eligibility categories, the provider may call the Audio Response Unit at (800) 392-0938. The provider needs the recipient's Medicaid number to receive the message that includes the recipient's ME code.

13.8 RECIPIENT COST SHARING AND COPAY

Recipients eligible to receive certain Missouri Medicaid services are required to pay a small portion of the cost of the services. Services of the MRDD Waiver Program described in this manual are not subject to a cost sharing or co-pay amount.

13.9 RECIPIENT NONLIABILITY

Medicaid covered services rendered to an eligible recipient are not billable to the recipient if Medicaid would have paid had the provider followed the proper policies and procedures for obtaining payment through the Medicaid Program as set forth in 13 CSR 70-4.030.

13.10 ADEQUATE DOCUMENTATION

All services provided must be adequately documented in the medical record. The Code of State Regulations, 13 CSR 70-3.030, Section (2) (A) defines "adequate documentation" and "adequate medical records" as follows:

Adequate documentation means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty.

Adequate medical records are records which are of the type and in a form from which symptoms, conditions, diagnoses, treatments, prognosis and the identity of the patient to which these things relate can be readily discerned and verified with reasonable certainty. All documentation must be made available at the same site at which the service was rendered, with the exception of in-home services such as personal care, home health, etc.

13.10. A DOCUMENTATION

Implementation of services must be documented by the provider and is monitored by the service coordinator at least monthly for individuals who receive residential habilitation or individualized support living and at least quarterly for individuals who live in their natural home. As per 13 CSR 70 – 3.030, the provider is required to document the provision of MRDD Waiver services by maintaining:

- First name, and last name, and either middle initial or date of birth of the service recipient.
- An accurate, complete, and legible description of each service(s) provided. This information may be included in daily activity records that describe various covered activities (services) in which the person participated.
- Name, title, and signature of the Missouri Medicaid enrolled provider delivering the service. This may be included in attendance or census records documenting days of service, signed by the provider or designated staff; records indicating which staff provided each unit of service; and documentation of qualifications of staff to provide the service.
- Identify referring entity, when applicable.
- The date of service (month/day/year). This can be included in attendance or census records.
- Amount of time in hours and minutes spent completing the service. Prior to 6/1/07, for those Medicaid programs and services that are reimbursed according to the amount of time spent in delivering or rendering a service(s) the actual begin and end time taken to deliver the service (e.g., 4:00 – 4:30 p.m.) must be documented. This excludes services such as residential,

home modification, equipment and supplies, transportation, etc. Effective 6/1/07 the begin and end time spent in delivering a service is no longer required.
- The setting in which service was rendered.
- Person centered plan, evaluation(s), test(s), findings, results, and prescription(s) as necessary.
- Service delivery as identified in the individual's person centered plan.
- Recipient's progress toward the goals stated in the treatment plan (progress notes). Sources of documentation include progress notes by direct care staff regarding situations (whether good or bad) that arise affecting the individual; and monthly provider summaries noting progress on individual's goals and objectives in their personal plan, and overall status of the individual.
- For applicable programs, include invoices, trip tickets/reports, activity log sheets, employee records (excluding health records), and staff training records.
- Applicable documentation should be contained and available in the entirety of the medical record.

All providers must follow the above documentation requirements unless otherwise noted under specific MRDD Waiver services in Sections 13.18 through 13.37. Any additional requirements for a specific service are also included in these sections.

13.10.B FINANCIAL COMPLIANCE

There are several ways that financial compliance is ensured:

- All services are prior authorized and traced through the Department of Mental Health's prior authorization system;
- Providers are required to keep specific records that detail the delivery of services as authorized and support evidence of service delivery to each individual on each date that services are billed;
- Service coordinators, during monthly or quarterly monitoring visits, ensure the delivery of services;
- Audits are conducted by the Department of Mental Health's Office of Audit Services and the Division of Medical Services' Program Integrity Unit; and
- The State Auditor's Office serves as the "independent audit" for waiver providers.

13.11 BILLING (MRDD)

All billings to the Medicaid Agency for Medicaid eligible MRDD Waiver services are sent to the Department of Mental Health. The Department of Mental Health processes the billing information through its contract and prior authorization system, then forwards it to the Medicaid Agency's fiscal agent for processing and reimbursement.

13.12 PLACE OF SERVICE (MRDD)

As the billing agent for DMRDD waiver providers, DMRDD is responsible for place of service information billed to Medicaid. An MRDD Waiver provider may provide care in the following places of service (POS):

11—Office

12—Home
99—Other

13.13 TYPE OF SERVICE (MRDD)

MRDD Waiver services are billed with type of service "9." Refer to Section 19 of the provider manual.

13.14 MRDD SERVICE LIMITATIONS

The following general limitations apply to all Medicaid services provided through a MRDD Home and Community Based Waiver Program:

- A service must be included in a plan of care authorized by a DMRDD Regional Center prior to its delivery.
- A service must relate to goals identified in the individual's person centered plan.
- Service activity for which the provider bills must be within the scope of the authorized service and the services must be rendered by appropriate and qualified individuals or professionals as defined in this manual and in State Regulation 9 CSR 45-5.030.
- The person must be eligible for Medicaid in an allowable eligibility category when the services are delivered (see 13.6).
- Medicaid does not cover services for individuals residing in a jail or detention facility.
- Medicaid waiver services are not available to individuals who are inpatients in a nursing home (including SF, ICF, ICF/MR), or a hospital.

Note: Services provided through the MRDD are NOT medical in nature; therefore, they are not ordinarily covered by private insurance. These services are not subject to the TPL edit—they are not billed to private insurance.

For participants in the Community Support Waiver, there are specific limitations on each service.

13.15 NONCOVERED SERVICES (MRDD)

The following services are ineligible for Medicaid payments under the MRDD Waiver:

- Room and board, except as provided through out of home respite care for approved live-in caregivers, as defined in the ISL service.
- Vocational rehabilitation available through the Office of Vocational Rehabilitation.
- Educational services provided under the Education of the Handicapped Act, which are available through the local educational agency.
- Services otherwise available under the state's Medicaid Plan, e.g., physician, pharmacy, personal care, hospitalization, therapies for children under 21, etc.

Section 13.16 PARTICIPANT DIRECTION OF SERVICES

For persons who live in their own private residence or the home of a family member, there are opportunities for them to self direct selected services available through the Missouri MRDD Waiver programs. Participants further may choose to direct how their negotiated individualized budget is to be expended to exercise control of their allocated resources.

Participant-directed personal assistant and in-home respite services are afforded through all three MRDD Waivers. Recent renewals of the MRDD Comprehensive and Community Support Waivers additionally include a participant-directed option for community specialist and a new support broker service. These aforementioned supports are also available through provider agencies.

Resources to support individuals who direct their services include the ability of the individual or representative to facilitate their own person-centered planning process, be assisted by a service coordinator employed by a regional center or approved County SB-40 Board, or choose an independent plan facilitator. The case manager and other staff employed by regional centers and SB-40 Boards can assist the individual and responsible party in understanding service options including self direction and transitioning provider driven services to self direction. Persons opting to self-direct their services are given the choice to recruit, hire, and supervise staff themselves, or may select a support broker (either agency based or employed by the family) under their direction to perform these duties.

When the individual chooses to self-direct and is the employer, fiscal management services are available to take care of payroll, taxes, insurance, workers compensation, recordkeeping, etc. The Division contracts with a state wide third party private entity to provide fiscal management services. Individuals who self-direct their services and hire employees will need to complete necessary forms to enroll as the employer of record and facilitate employee paperwork processing through the regional center. A service coordinator and/or support broker can assist with this process as well. Information flows through regional centers to the fiscal management agent as regional centers maintain the prior authorization system for consumer-directed services. MRDD Central Office staff coordinates activities between the fiscal management agent and the regional centers.

Detailed information about consumer-directed services in the DMH/DMRDD Waiver can be obtained through regional center and SB-40 Board service coordination and also logging onto the DMRDD website at www.dmh.mo.gov. There is also information on self-direction available on the Independence Plus Grant website at www.ihd.umkc.edu/independenceplus/index.htm

Descriptions, specifications, and requirements for each service are located in Section 13 of the DMRDD Waiver manual. Individuals hired as employees of the consumer/family for an

applicable service offered through Medicaid Waiver must meet provider qualifications and standards as identified for that service. The consumer/family employer may specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with those specified in the Waiver manual.

13.17 QUALIFIED MENTAL RETARDATION PROFESSIONAL (QMRP)

The following represents the minimum requirements for individuals to be considered qualified mental retardation professionals:

Psychologist: A person with at least a master's degree in psychology from an accredited school and with at least one year of experience in working directly with persons with mental retardation or other developmental disabilities.

Physician: A doctor of medicine or osteopathy who has at least one year of experience in working directly with persons with mental retardation or other developmental disabilities.

Social Worker: A person who holds a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body; or a person who holds a Bachelor of Social Work degree from a college or university accredited or approved by the Council on Social Work Education or another comparable body. The social worker must also have at least one year of experience in working directly with persons with mental retardation or other developmental disabilities.

Occupational Therapist: A person who is eligible for certification by the American Occupational Therapy Association or another comparable body and who has at least one year of experience in working directly with persons with mental retardation or other developmental disabilities.

Physical Therapist: A person who is eligible for certification by the American Physical Therapy Association or another comparable body and who has at least one year of experience in working directly with persons with mental retardation or other developmental disabilities.

Speech Pathologist or Audiologist: A person who is eligible for a Certificate of Clinical Competence in Speech-Language Pathology or Audiology granted by the Speech-Language-Hearing Association or another comparable body; or a person who meets the educational requirements for certification and who is in the process of accumulating the supervised experience required for certification. A speech pathologist or audiologist must also have at least one year of experience in working directly with persons with mental retardation or other developmental disabilities.

Registered Nurse: A person who is a registered nurse and who has at least one year of experience in working directly with persons with mental retardation or other developmental disabilities.

Professional Recreation Staff Member: A person who has a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education and who has at least one year of experience in working directly with persons with mental retardation or other developmental disability.

Human Services Professional: A person who has at least a bachelor's degree in a human services field (including, but not limited to: sociology, special education, rehabilitation. counseling and psychology) and who has at least one year of experience in working directly with persons with mental retardation or other developmental disabilities.

PROVIDER QMRP RESPONSIBILITIES:

Whether the provider facilitates the plan or participates in its development as a member of the interdisciplinary team, the provider Qualified Mental Retardation Professional (QMRP) Rev. 08/07 has the following responsibilities:

- Actively participate in the person centered planning proves,
- Provide supervision and training to direct support staff regarding implementation of person centered plan,
- Design support and teaching strategies, i.e., training plans, teaching methods for implementation,
- Ensure support and teaching strategies are referenced in the person centered plan,
- Make changes to support/teaching strategies to ensure progress toward achievement of outcomes and action steps,
- Regularly monitor the implementation of the person centered plan,
- Make necessary changes to the person centered plan outcomes based on collection of data, direct support feedback and observations of the consumer working toward plan outcomes. Outcomes may only be changed with the approval of the person, his/her guardian, and other members of the interdisciplinary team,
- Ensure that services and supports are provided as specified in the person centered plan. This includes, at a minimum, one face to face visit to observe the consumer receiving supports,
- Provide service coordinator with monthly reports on progress,
- Facilitate opportunities for natural supports,
- Document specific QMRP activities provided to the individual,
- Inform staff about the Missouri Quality Outcomes.